HUSBAND'S AND DAUGHTER'S ROLE STRAIN DURING BREAST CANCER PATIENT HOSPICE CAREGIVING AND BEREAVEMENT ADJUSTMENT

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Current literature regarding caregiver bereavement adjustment has advanced two competing models explaining adjustment in relation to caregiver interrole conflict: the Relief Model and Complicated Grief Model. This research has primarily focused on the experience of those providing care to dementia patients. This study tests these competing models of bereavement adjustment for husband and daughter caregivers of breast cancer hospice patients. For husbands, greater psychological strain and health strain were predictive of greater difficulty with bereavement adjustment, supporting the Complicated Grief Model of bereavement adjustment. For daughters, strain was not a significant predictor of bereavement adjustment, and thus did not support either bereavement adjustment model. While daughter caregivers experienced more role strain than husband caregivers during patient care, the degree of role strain was predictive of bereavement adjustment for husbands but not for daughters, suggesting that relationship type (husbands versus daughters) between caregiver and patient impacts which factors influence bereavement adjustment.

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CHAPTER I

HUSBAND'S AND DAUGHTER'S ROLE STRAIN DURING BREAST CANCER PATIENT HOSPICE CAREGIVING AND BEREAVEMENT ADJUSTMENT

Current medical technology has not only increased cancer patients' chances of disease remission, but has also prolonged the lifespan of those with terminal cancer. Today patients have an increasing number of alternatives to traditional hospital care. Concurrently, families are being encouraged to become the primary care providers, or they are finding themselves with no other option than to do so, both during the active treatment phase as well as throughout advanced stages of the illness (Stetz & Hanson, 1992) and throughout terminal hospice care. Taking on the responsibility of primary caregiver inevitably leads to necessary lifestyle changes in order to meet the demands of this new role. The addition of the caregiving role to the roles one already occupies requires varying degrees of adjustment throughout the caregiving process. Furthermore, the amount of interrole conflict that the caregiver experiences during hospice caregiving may also have consequences for later adjustment to bereavement after the death of the cancer patient.

Caregiving and Bereavement

With modern medical advances prolonging the life of terminally ill cancer patients, caregiving for such patients has become an increasingly lengthy process. With the increased length of this caregiving relationship also comes an increased investment and involvement in the relationship. Inevitably, the nature of the caregiving relationship will impact the caregiver's response to the death of the patient, as death marks the termination of this relationship. Therefore caregiving and bereavement should be viewed not as separate processes, but rather as part of a single chronic situation encompassing both the experience of caring for an impaired relative and the death of that relative.

These experiences are linked together in a chronic stress context in which the caregiver must adjust to the strain of caregiver responsibility and then readjust to the loss of this role (Bass, Bowman, & Noelker, 1991). Much of the literature examining adjustment to bereavement focuses on the bereavement experience itself without utilizing predeath measurements of potentially related factors or examining the potential for these predeath factors. However, due to the lengthy and intimate nature of the caregiving relationship between the family member and the terminally ill cancer patient, the caregiver's reaction to the expected death following illness should not be viewed in isolation from the caregiving situation prior to death (Bass & Bowman, 1990).

Numerous factors determine the nature of the caregiving relationship. Among other factors, these include the initial relationship of the caregiver to the patient, the degree of burden that the caregiving role places on the caregiver, the length of time spent caregiving, and the nature of the patient's illness and level of incapacity. As the nature of the caregiving relationship is multidimensional, so to is the caregiver's response to the death of the care receiver. Research has suggested that gender differences exist regarding adjustment to bereavement, however the findings are mixed as to whether males or females have more difficulty with adjustment. Stroebe and Stroebe (1993) conclude from their review of the literature regarding spousal bereavement that men have increased difficulties with bereavement adjustment than do women. This contradicts the findings of Gilbar and Dagan (1995) that suggest that adjustment to bereavement is more difficult for widows than for widowers of cancer patients. Such conflicting evidence suggests that the bereavement process is complicated and sensitive to many factors of the particular caregiving situation.

Interrole Conflict

One possible mediating factor that may influence bereavement adjustment is the degree of burden experienced by the caregiver throughout the caregiving process. According to the scarcity hypothesis, multiple roles lead to competing obligations for time and energy of the role occupant. When the combination of various role responsibilities becomes too demanding, people do not have enough resources to adequately fulfill their multiple role obligations. Role strain is experienced as difficulty in fulfilling one's role obligations (Mui & Marow-Howell, 1993). One source of role strain is role demand overload. This occurs when one has insufficient time and resources to fulfill all the obligations of his/her combined social and family roles (Mui, 1995). Another source of role strain involves the incompatibility of role expectations, which is labeled role conflict. Interrole strain and role conflict may result as one confronts and attempts to manage the competing expectations of two or more roles (Blanchard-Fields, Chen & Hebert, 1997). Consequently, multiple role commitments produce role strain in response to role demand overload and role conflict (Mui & Morrow-Howell, 1993; Walker, Pratt & Wood, 1993). This interrole strain has important implications for psychological well-being and satisfaction. To the extent that the caregiving role leads to increased obligations, the potential exists for the caregiver to experience role demand overload and role conflict.

Role Strain

According to the scarcity hypothesis, the more roles one occupies and/or engages in, the more difficulty that person will experience in fulfilling the obligations of each individual role situation because coping resources are limited. Research in the area of caregiver role strain has distinguished between two key forms of stressors as a basis of role strain. Primary stressors include those elements directly involved in the caregiving

process that lead to role strain, whereas secondary stressors include elements of the domains of life outside of caregiving (Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995). These secondary stressors have been noted as critical to changing the way the caregiver views oneself. The literature supports views that a variety of primary and secondary stressors interact in producing elevated interrole conflict and role strain, and that such conflict and strain negatively impact one's ability to function effectively in many different roles. For example, Barling, MacEwen, Kelloway, and Higginbottom (1994) found that in a sample of elder-care providers, higher levels of interrole conflict were associated with personal strain, which directly and negatively predicts quality of marital functioning. They concluded that the added responsibility of elder-care fostered interrole conflict and subsequently role strain as caregivers' resources depleted. In turn, caregiver strain had a negative impact on the quality of the marital relationship, as they had reduced ability to devote time or energy to this role in light of the added obligations of the caregiving role. Therefore, different aspects of elder-care involvement, interrole conflict, personal functioning, and marital interaction are all highly intercorrelated.

Likewise, interrole conflict and role strain could also impact the quality of other role relationships in addition to the marital relationship, such as that of parent, friend, or employee. To the extent that the caregiver engages in several roles outside of the caregiving relationship, there is more opportunity for role strain and interrole conflict, as well as more factors that may be likewise intercorrelated. Furthermore, the nature of the primary relationship between the caregiver and the care recipient, whether it be spousal or parent-child, may also be intercorrelated with role strain and interrole conflict, as the type of relationship carries unique factors into the caregiving situation and likewise influences role fulfillment outside the caregiving relationship.

Roles of Spouse Caregivers

Terminal cancer is of much greater prevalence in elderly than in younger populations. Therefore, as terminally ill cancer patients tend to be older, so do the spouse caregivers of these patients tend to be older. The various primary roles of the elderly tend to differ from those of younger adults, as they are at a different stage of life development. Familial roles of the elderly reflect a reduction in concurrent role responsibility, as particular roles are minimized or even eliminated (Rankin, 1990). For example, the roles of parent and worker are no longer as important as they were in mid-life, as children are now adults and far less dependent, and many elderly retire from the workforce. However, many roles still remain, even if they do so in a changed capacity. Elder caregivers may juggle the roles of parent, grandparent, friend, volunteer, etc. (Mui & Morrow-Howell, 1993).

Along with role changes, changes in personal and social resources occur throughout the lifespan as part of the normal aging process (Rankin, 1990). Accordingly, the elderly may experience diminished physical abilities, opportunities for social interaction outside of the family, and economic earning capacity. With a reduction in resources also comes a strain on one's ability to fulfill various role obligations that utilize such resources. To the extent that one has depleted resources, the responsibility of additional roles may be particularly taxing. Therefore, older individuals that suddenly find themselves in the caregiving role are at risk for experiencing greater role strain, as they may have fewer resources available to contribute to coping with caregiving obligations.

Furthermore, Mui and Morrow-Howell (1993) suggest that if older caregivers have unrealistic expectations regarding the caregiving role, they are at even greater risk for role stain and interrole conflict. Unrealistic expectations about the amount of

responsibility one can handle, in light of unfulfilled caregiving obligations, can manifest a feeling of inadequacy as well as create an added sense of burden and role strain. Therefore, to the extent that older caregivers have fewer resources to delegate towards caregiving and have unrealistic expectations for their ability to perform in the caregiving capacity than do younger caregivers, they are at heightened risk for role strain and conflict than their younger counterparts. This suggests that spouse caregivers of older patients may experience greater role strain than daughter caregivers, as spouse caregivers are likely to be much older than daughter caregivers.

Roles of Daughter Caregivers

The family roles of mid-life women are characterized by multiple and concurrent demands which may include marriage or remarriage, childbearing, child raising, career aspirations, obligations of being an adult daughter, and extra-family commitments (Rankin, 1990). All of these roles involve a considerable investment of personal time. Walker, Pratt, and Wood (1993) proposed that, in regard to spousal obligations, women bear a disproportionate amount of the responsibility for both the emotional work (e.g., identifying relationship problems) and instrumental work (e.g., housekeeping) of the marriage. Furthermore, work associated with parenthood is also disproportionately the responsibility of the mother. In addition, an ever growing number of wives and mothers are also seeking out employment and careers outside of the home. Research indicates that the combination of these three roles of spouse, mother, and employee may not be particularly stressful (Walker, Pratt & Wood, 1993). However, when the role of caregiver to an aging parent is added to one's responsibilities, this is often described as burdensome and a difficult experience for women. In a study of interrole conflict and psychological distress, Stephens, Townsend, Martire, and Druley (1998) found that conflict between the role of caregiver to a parent and other roles helped explain the relationship between

caregiver stress and women's psychological well-being. These findings suggest that caregiving for a parent negatively impacts the daughter's well-being as it drains the daughter's resources of time and energy, particularly when the demands of the caregiving role conflict with her ability to meet the demands of other roles.

Most daughter caregivers are mothers themselves, with approximately 25 percent of these mothers having minor children that still live in the home during the period of caregiving. Research examining the effects of maintaining both the role of caregiver and mother has consistently demonstrated that mothers have more difficulty with the caregiving experience than their childless counterparts, experiencing lower overall well-being and life satisfaction (Walker, Pratt, & Wood, 1993). Thus, the interrole conflict between caregiving and motherhood produces global personal strain that can negatively impact the caregivers' functioning in both roles. As the need to spend time mothering may reduce the amount of time or quality of caregiving, so too may the demands of caregiving interfere with the amount of time or quality of mothering.

This relationship of role demands and functioning in caregiving and other roles is somewhat different in regard to employment. While approximately 44 percent of caregiving daughters are employed, employment is unrelated to the amount of time that they spend in the caregiving role (Walker, Pratt, & Wood, 1993). When role demands of employment and caregiving compete for time and resources, daughter caregivers are much more likely to sacrifice work responsibilities in favor of caregiving obligations, therefore they reduce working hours rather than caregiving hours. Therefore, caregiving is more apt to have a negative impact on career roles and promote strain in this area, rather than career obligations impacting caregiving obligations.

Thus it appears that daughters who assume the role of caregiver are at added risk for interrole conflict in that they experience an increase in role demands beyond that of

their primary and already existing roles, such as mother and employee, with the addition of the role of caregiver. Such an increase in role obligations can produce an increase in personal strain, in turn having a negative impact on the quality of the caregiver's ability to function in either or all roles in which she is involved. Whereas evidence for increased interrole conflict and role strain due to the added burdens of caretaking exists, Walker, Pratt and Wood (1993) found that daughters experienced infrequent conflict from the occupancy of these multiple roles of caregiver, spouse, mother, etc. Their findings suggest that even though the potential for role strain and burden exists, in general the levels of role strain or burden experienced by daughter caregivers may be relatively low.

Spouse Vs. Daughter Sources of Role Strain

Along with the changing roles and resource availability that come along with age and life stage developemnt, sources of stress from providing care may also differ according to characteristics of the type of caregiver, whether it be a spouse or a daughter (Rankin, 1990). Examination as to the specific sources of caregiver stress indicates that the stress experienced by husband caregivers was primarily associated with his physical and financial status, whereas the stress experienced by daughter caregivers was primarily associated with competing role obligations outside of the caregiving relationship. Therefore, limited personal resources may be the dominant source of stress for husbands in the caregiving role, while daughters are more burdened by the interaction of tasks and responsibilities that exist in addition to their role as caregiver.

Research has found evidence that sex differences exist in various aspects of the caregiving relationship. Mui (1995) found differences between male and female spouse caregivers with respect to the meaning they associated with the caregiving role, their role preparedness, role satisfaction, and role expectations. While these findings are limited to the spousal role, these factors should be examined in terms of other caregiving

relationships. To the extent that gender role differences prepare the sexes to engage in various other roles differently, these gender differences may also be found throughout other caregiving relationships. Accordingly, the differences in perceived meaning, role preparedness, role satisfaction, and role expectations may also be applied to other caregiver relationships and may be predictive of differences in strain between various groups of caregivers. Therefore, not only are wives' and husbands' caregiving experiences different, but male caregiving experiences may also be seen as distinct from female caregiving experiences. Thus, the particular type of relationship that the caregiver has to the patient may be an important factor in predicting role strain and the ability to adjust to the caregiving situation.

Consequently, the spouse caregiving experience may differ from other caregiving relationships, such as daughter caregivers. Rankin (1990) proposed that a fundamental difference exists between spouses' and daughters' perception and definition of their caregiving roles. Daughter caregivers were more likely to define functional problems in terms of the custodial or supervisory role (e.g. decision making regarding care, management of the patient's finances) played within the caregiving relationship, whereas spouses more likely perceived the role of caregiver as primarily involving the fulfillment of general needs like assistance with daily care and enrichment activities (e.g. housework, care for patient's hygiene, maintaining social contacts). This difference in perception of primary obligations will presumably impact one's notion of the specific task demands of the caregiving role. In so far as different task demands place varying degrees of strain on the individual, different definitions and perceptions of the caregiving role will in turn lead to different degrees of risk for role strain.

Role Strain and Well-being

With the acceptance of the caregiving role comes profound changes in the organization of one's life to meet the demands of caregiving. Caregiving involves multiple responsibilities including providing nourishment, aiding in personal hygiene, overseeing finances, and emotional support to list a few. As the patient becomes more dependent on the caregiver, the number of caregiving obligations increases, and likewise the amount of time and effort that the caregiver needs to devote to fulfilling these obligations also increases. Such an increase in the demands of the caregiving role may force the caregiver to reduce other role obligations outside the realm of caregiving, including family roles as spouse and parent, household roles as cook, housekeeper, maintenance, career roles as employer, employee, co-worker, and social roles as friend, club member, teammate, etc. Time spent engaged in social and leisure activities are frequently the first area of sacrifice, as these roles are typically viewed as not as important as others.

As caregivers focus their attention to the caregiving role at the expense of fulfilling other role obligations, role engulfment and a sense of self loss may result (Skaff & Pearlin, 1992). This loss of a sense of self through role engulfment is supported by Mui and Morrow-Howell (1993). They found that spouse and sibling caregivers experienced role strain that was influenced by both a lack of respite support and perceived conflict in their personal and social lives. Furthermore, as caregiving obligations limit caregiver's social contacts and reduce their social roles outside of the caregiving role, caregivers experience a greater loss of their sense of self, decreased self-esteem, and increased depression. Strain between caregiving roles and other social roles can also have a negative impact on the caregiver-care recipient relationship. Walker, Pratt and Wood (1993) found that thirty percent of daughter caregivers experienced

conflict between obligations related to caregiving for their mother and their other social roles. When the perceived role conflict existed between their caregiving role and their role as wife, their caregiver-care recipient relationships were poorer. Together these findings confirm that stressful experiences within the combination of both caregiving and non-caregiving roles are associated with negative outcomes.

However, additional evidence suggests that the nature of the caretaker's relationship to the patient may influence the impact of the consequences of role strain. Mui (1995) examined the effects of role strain on a sample of spouse caregivers and demonstrated that conflict between caregiving obligations and personal and social lives had an effect on physical, financial, and emotional well-being. However, this role conflict had a significantly stronger effect on husband caregivers than on wife caregivers. Mui suggested that wives are more invested than husbands in the caregiving role. While the husbands were able to assume the caregiving role, they still remained active socially and wanted involvement in other social activities. Therefore, lifestyle restrictions outside of caretaking may frustrate the husband more than the wife caregiver.

Skaff and Pearlin (1992) found that spouse caregivers experienced a greater sense of self-loss than adult child caregivers. These results are explained in terms of opportunity outside the caregivng role to evaluate oneself and reshape self-concepts. The number of relationships one has decreases as people age. In addition, caregiving often requires the reduction of time spent engaging in these outside relationships (Bodnar & Kiecolt-Glaser, 1994). To the extent that spouse caregivers are older than daughter caregivers, they have fewer outside relationships in which to engage. Thus, they have fewer outside sources of self-evaluation, which can intensify the salience and impact of one's experience within the caregiving role. Further research examining the nature of the caregivers relationship to the care recipient and the impact that this relationship has on

role strain and its consequences is warranted, but it appears that to the extent that relationships differ and other roles outside of caregiving differ, the impact of caregiver role strain would also likely differ.

Caregiver Strain and Bereavement

A limited number of studies have examined caregivers' experiences of bereavement, therefore little is known about caregivers' response to the death of the care recipient or how the experience during caregiving affects later bereavement adjustment (Aneshensel et al., 1995). Furthermore, the majority of studies examining the caregiver experience have used populations of dementia patients. Therefore, the relationship between caregiving and bereavement adjustment for patients of other forms of physical illness is extremely limited. Dementia entails many cognitive impairments, such as impaired memory for the identity of and relationship with the caretaker, that are not likely found in other medical illnesses, such as breast cancer. Such differences in symptoms are presumed to have implications for the nature of the caregiving relationship and later bereavement adjustment of the caregiver. To the extent that caregiver experience would seemingly differ depending on the nature of the patient's illness, research in the area of caregiver experience and bereavement needs to expand to other medical populations and circumstances.

Past research in the area of caregiving and bereavement has also been limited by the perspective that these are two separate processes, which has guided researchers to generally treat caregiving and bereavement as two distinct events. Caring for a terminally ill relative involves three stages: caring for the impaired relative, the death of relative, and the survivors' adjustment to the death. These three stages are a combined process that are linked together in a chronic stress context in which the stress of each stage is cumulative. Therefore, the meaning of the care recipient's death and the impact on the

survivors needs to be examined in relation to the long-term caregiving situation that precedes the patient's death. Much of the bereavement research fails to include characteristics of the predeath caregiving situation, therefore omitting key determinants of postdeath adjustment (Bass, Bowman, & Noelker, 1991). Of studies that do examine caregivers' bereavement in relation to the caregiving experience, few have collected information prior to the patient's death, therefore most information is retrospective.

Models of Bereavement

The literature regarding caregivers' bereavement adjustment to the death of the care recipient has suggested two competing models that make opposite predictions of death-related distress. In general, these two opposing models suggest different outcomes in terms of postdeath bereavement symptoms. One model predicts that caregiver strain diminishes upon the death of the care recipient, and the reduction in stressful obligations provides a sense of relief and eases the bereavement process. This is known as the Relief Model of bereavement. The opposing model suggests that caregiver strain disrupts the ability to provide a sense of closure to the relationship, leaving many relationship issues unresolved at the time of the care recipient's death. In turn, the unresolved nature of the relationship complicates the bereavement process. This is known as the Complicated Grief Model of bereavement.

The Relief Model

The Relief Model of bereavement proposes that those who experience increased caregiver strain during caregiving will experience postdeath caregiver relief as the stress associated with caregiver obligations is alleviated. The relief of responsibilities frees the individual to reestablish roles that might have been neglected during caregiving, such as employment, social functions, or time with children. The relief of responsibilities and caregiver stress also frees valuable psychological resources, allowing the individual to better cope and adjust to the care recipient's death. Therefore this model predicts that the

diminished demand of stressful caretaking obligations provides a sense of relief that eases the bereavement process so that these individuals would experience less difficulty with bereavement adjustment.

Caregiver strain is alleviated almost immediately after the death of the care recipient, as the caregiver role obligations are immediately terminated. Mullan (1992) found evidence that major stressors associated with caregiving were completely eliminated during the first year post-death. Furthermore, caregivers experienced relief almost immediately after the death of the care recipient as measured in terms of a significant drop in feeling overloaded as well as an increased sense of mastery in their lives.

The effects of reduced caregiver strain have also been seen to impact the bereavement adjustment of the caregiver's immediate family. Bass, Bowman, and Noelker (1991) found that those who experienced heightened personal caregiver strain later had lower levels of postdeath family bereavement difficulties.

The family unit experienced eased bereavement adjustment with the caregiver's relief of stressful obligations. This suggests that the strain experienced by the individual caregiver likely impacted the entire family unit. Subsequently, when the caregiver was relieved from the burdens of providing care due to the patient's death, the caregiver is able to return to higher quality functioning within the family unit roles, which in turn lessens the difficulty of bereavement for the family. Caregiver role obligations often prevent the caregiver from fulfilling other roles, including family roles such as spouse, parent, or wage earner. In turn, other family members may need to step into various aspects of the roles and take on additional household responsibilities to keep the family system functioning. This causes role strain for the other family members. Therefore, while research has not investigated the exact process by which family bereavement adjustment

is eased in this system, it is suggested that the caregiver, once freed from caregiver responsibilities that hindered fulfillment of one's family role obligations, may return quickly to the family roles and in turn relieve other family members from their added burdens. Furthermore, the caregiver may also have increased capacity to support other family members emotionally. However, further research is needed to clarify this complex system. In addition, these results are contradictory to Bass et al.'s (1991) previous work that did not find significant results for eased family bereavement adjustment. Therefore, research support for the relief model is limited and needs to be further investigated.

Complicated Grief Model

The Complicated Grief Model is based on the idea that increased role strain predicts increased difficulty with bereavement. Two main explanations are proposed for the increased difficulty with bereavement adjustment, both of which emphasize extended exposure to stressors, which is characteristic of terminal cancer. First, the stress of caregiving accumulates over time and circumstances and diminishes the supply of psychological resources for coping with the strain of bereavement. Second, the stressful obligations and multiple responsibilities of caregiving interfere with the resolution of the relationship, a sort of saying good-bye process, with the patient prior to death, such that unresolved relationship issues (i.e., lack of closure) between the caregiver and care recipient make the bereavement process more difficult.

Stress theories indicate that the intensity of stress created depends on the extent to which perceived demands of a situation tax or exceed one's coping resources. In addition, multiple successive stressors often have a cumulative negative effect as the amount of stress continues to accumulate across stressful situations and deplete psychological resources available for coping. Given that a failure to cope leads to important negative consequences, when coping capacity is exhausted, an individual is even more vulnerable

to those negative consequences (Bass & Bowman, 1990; Stroebe & Stroebe, 1993). The role of caregiver involves multiple taxing obligations to the care recipient, which in turn often impair one's ability to fulfill other role demands aside from caretaking. Therefore, the caregiver is vulnerable to multiple stressors, both directly and indirectly related to caretaking. This caregiving stress may continue to accumulate throughout the caregiving process. To the extent that these stressors do accumulate, at the time of the care recipient's death, the caregiver's coping resources will be greatly depleted and the caregiver will be particularly vulnerable to negative consequences from his/her diminished ability to cope. In particular, resources for coping with bereavement will be lessened, making adjustment to bereavement more difficult. Accordingly, those who experienced greater caregiver stress will have poorer coping capacity at the time of the care recipient's death, and likewise would experience more difficulty in bereavement adjustment.

Because the nature of terminal cancer usually involves an extended period of illness with the known outcome of death, the opportunity for anticipatory grief is present, in which the family members may start to grieve the loss of the cancer patient prior to the patient's death. Some grief models have suggested positive effects of anticipatory grief due to forewarning and opportunity to prepare for death, which include an ability to facilitate closure to the relationship (Aneshensel et al., 1995). However, from the perspective of hospice care, the duration of caregiving may be an indicator of hardship by assessing the length of exposure to caregiving stressors. Some research findings suggest that a lengthy caregiving period may offset the potential positive effects of anticipatory grief. Caregivers who experience stress with their caregiving obligations are most likely those who are devoting greater amounts of time to their caregiving role. Also, as caregiver stress accumulates with time and circumstances of caregiving, extended periods

of caregiving are going to increase the caregiver's vulnerability to diminished coping capabilities. Because of both limited time outside of caregiving duties and depleted coping capabilities, the caregiver is not as likely to prepare for death as a result of being enmeshed in the caregiving relationship. The nature of the caregiving relationship will therefore hinder the caregiver's preparation for death. Furthermore, the growing amount of care recipient's dependency on the caregiver over extended caregiving increases the level of commitment and closeness on the part of the caregiver to the relationship. In turn, the growing dependency increases caregiver's responsibilities and likewise often increases the amount of time necessary to spend in this role, in turn further isolating the caregiver from other relationships and fulfillment of other roles. Together, these negative consequences of extended caregiving are likely to offset the positive effects of anticipatory grief and in turn complicate adjustment to the patient's death.

The caregiver's appraisal of the nature of the caregiving relationship may impact his/her perception of the patient's death. Bass and Bowman (1990) found that the family caregivers that appraised caregiving as being a more serious problem also tended to perceive the care recipient's death as more serious. Those who appraised caregiving as a more serious problem were assumed to be under more caregiving strain, whereas those who appraised the patient's death as more serious were considered to be experiencing more difficulty with bereavement adjustment. Thus they concluded that increased caregiver strain predicts increased bereavement strain, suggesting that family members who perceive caregiving as more difficult are at risk to experience more troublesome postdeath adjustment. In addition, caregivers who perceive caregiving as difficult, and hence view themselves as having not adequately fulfilled their caregiving responsibilities, may experience guilt for not having been able to do more for the patient. Bodner and Kiecolt-Glaser (1994) found that caregivers who continued to ruminate about their former

caregiver role, feeling as though they had not adequately met their caregiving responsibilities, experienced increased stress, depressive symptoms, and social isolation during bereavement. Therefore, the ability to fulfill one's caregiving role obligations, as mediated by the amount of role strain experienced, has implications for later adjustment to bereavement.

Models to be Tested and Hypotheses

The Relief Model and the Complicated Grief Model predict contradictory outcomes of bereavement adjustment. According to the Relief Model, higher levels of caregiver strain would predict easier bereavement adjustment to the extent that the caregiver is relieved of the high level of stress associated with the caregiving role. As the caregiver returns to the premorbid activity levels of his or her primary roles, adjustment to the death of the patient is predicted to be eased. On the other hand, the Complicated Grief Model predicts that with greater caregiver strain, the caregiver becomes engulfed with the caregiving role at the expense of his of her primary relationship with the patient, either as spouse or daughter. As a result, the caregiver is unable to prepare for the death of the patient and may experience guilt for not resolving any relationship issues with the patient while the patient was alive. This guilt and lack of closure is predicted to heighten the difficulty of adjusting to the patient's death. While the literature in this area is limited, it does provide some support for each model. However, because research in this field provides such inconsistent support for any one model, the possibility of other mediating factors is apparent.

This study proposes that the nature of the caregiver's relationship with the patient is one such moderating factor. The primary role that one holds with the patient carries with it different obligations and expectations for the relationship. To the extent that the nature of the parent-child relationship differs from the nature of the spousal relationship,

so too may the nature of the child-as-caregiver role differ from the nature of the spouse-as-caregiver role. In turn, the process of relationship resolution and the loss experienced at the end of these relationships is also likely to differ. Therefore it is hypothesized that bereavement adjustment may follow different patterns depending on the nature of the caregiver's relationship with the patient, in this case, whether the caregiver is the spouse or the adult daughter of the breast cancer patient.

The spousal relationship is one based on a substantial amount of interdependence, in which responsibilities are shared and/or reciprocated, including those of emotional support, household maintenance, family care, and financial stability. With the death of a wife, in addition to grieving the loss of a companion, the surviving husband has the added burden of having to fulfill the responsibilities to which his wife had previously attended. Thus, even though the strain of caregiving is diminished with the death of the patient, the husband now faces continuing added responsibilities that can deplete his psychological resources for coping with his loss, thus complicating the bereavement process. A greater amount of role strain experienced prior to the patient's death is going to leave the husband with less psychological resources to cope with the added role strain he may experience after her death, whereas spouses who do not experience role strain prior to their wife's death may have greater coping resources available at the time of death to aid them in the adjustment process. Because husbands will experience a continued increase in the amount of family and household responsibilities that they will need to attend to in their wife's absence, they are not likely to experience a significant period of relief as predicted by the Relief Model. Therefore it is hypothesized that husbands' bereavement adjustment will be predicted by caregiver strain in accordance with the Complicated Grief Model, such that husbands with greater caregiver strain will experience more complicated bereavement adjustment than husbands with less caregiver strain.

The relationship between a mother and her adult daughter generally involves much less interdependence than that of a spousal relationship, particularly if the daughter has established her own family outside of the parent's household. Therefore, the experience of adult daughter caregiver strain occurs as the caregiving role adds to other role responsibilities associated with her primary household. Throughout the caregiving process, the daughter who experiences heightened role strain is likely to reduce her activity levels in her other roles, possibly eliminating some roles to help alleviate this strain. With the death of the parent, the daughter is able to reestablish her level of involvement in her other roles, returning to a previous level of functioning in these areas. To the extent that the daughter is both relieved of the strain of caregiving and can return to other social roles, she may find support and heightened coping resources to help her adjust to the grieving process. Therefore it is hypothesized that daughters experiencing heightened caregiver role strain will likely exhibit a pattern of bereavement adjustment that follows the Relief Model. Whereas husbands have to adjust to new roles and responsibilities after the death of their spouse, daughters are less likely to have to take on new responsibilities that their mothers held, and in turn they are also able to return to prior roles at the original level of functioning because they are not having to adjust to additional roles. Therefore, the nature of the relationship the caregiver has with the patient, whether spouse or adult daughter, has many implications for the process of bereavement adjustment, and such adjustment patterns may differ accordingly.

CHAPTER II

METHOD

Participants

Data for this analysis are from the National Hospice Study (Greer & Mor, 1987), which examined the impact of hospice care on the quality of life experienced and health care costs incurred by terminal cancer patients and their families. Over 12,000 cancer patients and their primary caregiver were identified at 40 hospices and 14 conventional oncological care settings across the United States. Eligibility to participate was based on: a) metastatic cancer confirmed by tissue diagnosis, b) age 21 or older, c) for conventional-care patients, a Karnofsky Performance Status Scale score of 50 or less, and d) a primary caregiver who provided substantial emotional and caretaking support for the patient. Data for this analysis were gathered from hospice patients and their primary caregivers selected by predetermined criteria from the original population. This subsample consisted of 213 breast cancer patients, with 126 having husbands as primary caregivers and 87 having daughters as primary caregivers.

Breast cancer patients ranged in age from 33-82 years ($\underline{M}$=65.6), on average had a high school diploma, and were predominantly White (93%). Of the patients with daughter caregivers, 72% were widowed and 17% were married. As expected, husband caregivers on average were older than daughter caregivers, with mean ages of 63.9 years and 41.4 years, respectively. Husband and daughter caregivers did not differ in years of education, employment status, or yearly income. All of the husband caregivers lived with their wives, whereas 62% of daughter caregivers lived with their mothers. Of daughter caregivers, approximately 61% were currently married, 17% had never been married, 14% were divorced, and 6% were widowed.

Procedure

Personal interviews with the patient and the principle caregiver were conducted at study entry. Hospice patients and principle caregivers were initially interviewed within a few days of referral by participating physicians and oncology nurses. Due to the advanced disease condition of the patients and the caretaking stress of the principle caregiver at the time of participation, interviews were short. A first follow-up contact with the patient and the principle caregiver occurred one to three weeks later and was repeated every two weeks thereafter until the patient's death. These follow-up contacts focused primarily on patient outcomes, although the principle caregiver also provided information on his or her own condition and attitudes, presented a record of all health services utilized by the patient, and reported on the patient's condition. Approximately three to four months after the patient's death, a bereavement interview was conducted with the principle caregiver. This measure assessed the medical, social, and psychological status of the principle caregiver and summarized records of the patient's use of health services while alive.

Materials

A subsample of questions from the following interviews were used for data analysis.

Intake/Discharge Form: Intake/Discharge forms were completed for all patients and included basic demographic information about the patients as well as their cancer diagnosis history and status, which was used for participant selection.

Initial Principle Care Person Interview: This interview was conducted during the initial visit with the patient and her primary caregiver. Caregivers responded to questions covering a wide range of topics concerning both the patient and the caregiver, including caregiver demographics and lifestyle and health changes since caring for the patient,

including occupational, financial, social, and family changes, and physical conditions. Sample questions topics include the degree to which the caregiver experienced reduced leisure activity, reduced financial resources, change in employment role or status, or changes in health since caring for the patient.

Follow-up Principle Care Person Interview: This 10 minute interview contained measures of family quality of life during caregiving, including questions referring to caregiver's satisfaction with the patient's care, secondary morbidity experienced by the family, and an assessment of difficulties incurred with continuing support to the patient. It was administered approximately three weeks after the Initial Principle Care Person and Patient Interviews.

Bereavement Interview: The Bereavement Interview was a 20 minute interview conducted with the principle caregiver between 90 and 100 days after the patient's death. It provides an index as to the principle caregiver's bereavement adjustment. It contained the same set of measures as the Follow-up Principle Care Person Interview. In addition, the Bereavement Interview included a subset of questions from the Grief Experience Inventory (GEI) (Sanders, & Mauger, 1979; Sanders, Mauger, & Strong, 1985) used in previous studies of bereavement. GEI items assess the existance of psychological symptoms of grief including guilt, helplessness, yearning, anger, apathy, and depression, as well as items measuring the existance of physical symptoms such as crying, headache, and muscle tension. The condensed version of the GEI had an internal consistency reliability coefficient of .91 for this data, and the condensed Despair subscale had an internal reliability coefficient of .84 for this data.

CHAPTER III

RESULTS

Mean Comparison of Psychosocial Factors

Table 1 contains comparisons of demographics as well as psychosocial measures between husband and daughter caregivers. Daughter caregivers experienced more Anxiety/Depression Symptoms and greater Family Strain during caregiving than husband caregivers. However, husband and daughter caregivers did not differ in Loss/Depletion of Resources during caregiving nor in Grief Experience and Despair ninety days after the patient's death. Daughter caregivers living with their mothers experienced more despair 90 days after their mother's death than those who were not living with their mothers, $t(52)=2.159$, $p<.05$. Daughter caregivers living with their mothers and not living with their mothers did not differ in Grief Experience, Anxiety/Depression Symptoms, Loss/Depletion of Resources, or level of strain for any of the caregiver strain categories.

The site of the patient's death varied primarily between three locations: home (34.6%), inpatient hospice (18.8%), and acute hospital (46.1%). These percentages are stable across the two types of caregiver relationships, husbands and daughters. Analysis of variance indicated differences in caregivers' grief 90 days after the patient's death ($F(2,115)=3.70$, $p<.05$). Post hoc Tukey HSD test indicated greater grief if the patient died in an acute hospital ($M=.39$) than if she died at home ($M=.28$). However, individual group analyses for husband and daughter caregivers did not indicate that either group experienced differences in grief or despair based on the site of the patient's death.

Participant Attrition

For this study, only participants present at both the initial intake interview and the three-week follow-up interview were included. Of the participants with complete date records, eighty-four percent of participants who completed the intake interview but did

not complete the 3-week follow-up interview were those caregivers for whom the patient had died prior to four weeks in hospice care. Attrition analysis comparing those caregivers that did not complete the three-week interview, even though the patient was still alive, to those caregivers that did complete the interview could not be computed due to small number of those voluntarily discontinuing with complete date records.

Factor Analysis of Caregiver Strain Items

Thirty-seven items were initially selected based on face-validity criteria that they were representative of different aspects related to caregiving strain. However, for the factor analysis, items with little or no variance were eliminated. These eliminated items from the follow-up interview include: "I seldom feel depressed," "I am usually happy," "(Experienced) Increased family closeness, intimacy," "Felt well all or most of time," "Had plenty of energy," "Satisfied with ability to meet patient's needs," and "Nurses listen to my concerns if I want them to." The remaining thirty items were entered into the factor analysis.

Using a principle-component factor analysis, both a two- and a three-factor solution were examined. For both solutions, the first two factors appeared to be the same and were interpretable. However, for the three-factor solution, the third factor was not interpretable according to any conceptual understanding. Therefore the two-factor solution was selected as the most useful. After selecting this factor solution, items were eliminated, selecting the highest loading items to remain while removing items that cross-loaded. Less strongly loaded items were retained on the factor only if they made conceptual sense. Table 2 contains the retained items and their respective loadings. Items 1-8 were retained for the first factor labeled "Anxiety/Depression Symptoms," while items 9-14 were retained for the second factor labeled "Loss/Depletion of Resources." Factor subscale scores were calculated as the mean of items 1-8 for the

Anxiety/Depression Symptoms subscale and the mean of items 9-14 for the Loss/Depletion of Resources subscale.

It was initially thought that this factor analysis might generate factors that would separate the different areas of life strain that caregivers experience. While these factors did not emerge, specific questions from the caregiving interviews address these areas of life strain and were examined. Six categories of life strain were constructed based on the face validity of these items: 1) Employment/Financial Strain, 2) Family Strain, 3) Social/Leisure Strain, 4) Caregiving Strain, 5) Psychological/Emotional Strain, and 6) Health Strain. These life strain area categories, along with their individual items, are presented in Tables 3 and 4, with their correlations with the Grief Experience and Despair for husband and daughter caregivers respectively.

For husband caregivers, Psychological/Emotional Strain was strongly correlated with Grief Experience, $r = .50$, $p < .01$, and with Despair, $r = .52$, $p < .01$. In this category, taking medication to control nerves or depression was moderately correlated with Grief Experience ($r = .35$, $p < .05$) and Despair ($r = .41$, $p < .01$), increased use of alcohol was moderately correlated with Grief Experience ($r = .35$, $p < .05$) and Despair ($r = .35$, $p < .05$), and difficulty sleeping was moderately correlated with Grief Experience ($r = .41$, $p < .01$) and Despair ($r = .38$, $p < .05$). Family and friends being helpful and supportive had a moderate negative correlation with Grief Experience, $r = -.37$, $p < .05$. Being under considerable pressure was also correlated with Grief Experience, $r = .31$, $p < .05$. In the category of Health strain, husband caregivers' experience of headaches was moderately correlated with Grief Experience ($r = .35$, $p < .05$) and Despair ($r = .31$, $p < .05$), and cold sweats was moderately correlated with Grief Experience ($r = .30$, $p < .05$) and Despair

(r = .34, p < .05). For daughters, the only significant correlation was change in weight with Grief Experience, r = .30, p < .05.

Predictors of Caregiver Grief Experience and Despair

The empiracally derived caregiving factors of Anxiety/Depression Symptoms and Loss/Depletion of Resources, along with caregiver age were tested for their ability to predict caregiver grief 90 days after the patient's death, as measured by either the Grief Experience Inventory (GEI), or a Despair subscale of the GEI. The three independent variables were forced into the two regression equations. For husbands, standardized regression coefficients and their t test significance for each independent variable are presented in Tables 5 and 6. For husband caregivers, age and Anxiety/Depression Symptoms significantly predicted grief, $F(3,44)=5.04$, $p< .01$. The R^2 for the equation is moderate; 27% of the variation in grief is explained by this model. Examining zero-order correlations, Anxiety/Depression Symptoms were positively correlated with Grief Experience, r = .43, p < .01, and caregiver age was negatively correlated with Grief Experience, r = -.33, p < .01. Anxiety/Depression Symptoms was the only significant predictor of despair, $F(3,44)=3.10$, $p<.05$. With a moderate R^2 , 19% of the variation in despair is explained by this model. Anxiety Symptoms were moderately correlated with Despair, r = .39, p < .01.

For daughters, standardized regression coefficients and their t test significance for each independent variable's ability to predict grief and despair are presented in Tables 7 and 8, respectively. Neither Anxiety/Depression Symptoms, Loss/Depletion of Resources, nor caregiver age significantly predicted grief or despair. For daughters, caregiver age had a moderate negative zero-order correlation with Grief Experience, r = -.36, p < .01.

Hierarchical regression was used to examine which of the six categories of life strain constructed from caregiver interview items were predictive of later grief and despair, as measured with the bereavement interview. For husbands, standardized regression coefficients and their t test significance for each independent variable's ability to predict grief and despair are presented in Tables 9 and 10, respectively. For husband caregivers, greater Psychological/Emotional Strain and greater Health Strain during caregiving predicted greater Grief Experience at bereavement, $F(2,43)=10.70$, $p < .01$. The R^2 for the equation is moderate; 34% of the variation in grief is explained by this model. For husband caregivers, greater Psychological/Emotional Strain and greater Health Strain during caregiving also predicted greater Despair at bereavement, $F(2,43) = 10.38$, $p < .01$. The R^2 for the equation is moderate; 34% of the variation in despair is explained by this model. For daughter caregivers, none of the life strain categories were predictive of Grief Experience or Despair at bereavement.

Stability of Symptoms from Caregiving to Bereavement

Some of the items asked at the three-week interview and included in the Anxiety/Depression Symptoms factor were also asked at the bereavement interview and included in the Grief Experience Inventory, therefore these items were examined for stability over time with correlations and t tests. Husband caregivers showed a trend towards experiencing greater anxiety symptoms during caregiving than during bereavement, $t(44) = 1.91$, $p = .063$. Daughter caregivers experienced greater Anxiety/Depression Symptoms during caregiving than during bereavement, $t(43) = 2.22$, $p < .05$. As a measure of stability, for both husband and daughter caregivers, moderate positive correlations were also found between the Anxiety/Depression Symptoms factor during caregiving and the scale combination of these same items 90 days after the patient's death ($r = .40$, $p < .01$ for husbands, and $r = .30$, $p < .05$ for daughters).

Individual items of the Anxiety/Depression Symptoms factor were also examined for stability from the caregiving interview to the bereavement interview. Tables 11 and 12 contain the means and t test results for these individual items for both the three-week follow-up and bereavement interviews for husband and daughter caregivers respectively. Husband caregivers experienced greater pressure during caregiving than at bereavement, $t(44) = .4.52$, $p < .01$. Husband caregivers had no significant correlations for items between the two interviews. Daughter caregivers experienced more headaches ($t(42) = 2.46$, $p < .05$), greater family tension ($t(43) = 2.29$, $p < .05$), and were under more pressure ($t(43) = 4.65$, $p < .01$) during caregiving than at bereavement. For daughters, change in appetite was moderately correlated across the two interviews, $r = .32$, $p < .05$, and cold sweats was strongly correlated, $r = .54$, $p < .01$.

CHAPTER IV

DISCUSSION

Differences in Husband and Daughter Caregiving

In this study, daughter caregivers experienced more anxiety symptoms and greater Family Strain during caregiving than husband caregivers. This finding reflects the numerous studies reporting that female caregivers provide more care, as well as experience greater strain with caregiving, than male caregivers (Horowitz, 1985; Stone et al., 1987; Scharlach, 1987). Research indicates that female caregivers experience greater burdens leading female caregivers to experience higher levels of emotional and physical stress than male caregivers (Horowitz, 1985; Scharlach, 1987; Kramer & Kepnis, 1995). Kramer and Kepnis (1995) found that female caregivers of elderly relatives reported considerably higher levels of emotional and time strains than male caregivers. They concluded from their study that gender was a significant predictor of caregiving burden even when caregiving tasks, work-role strain and available resources were taken into consideration. In addition, Bass and Bowman (1990) cite limited research that compared spouse to adult-child caregivers and found that adult children reported greater emotional and family difficulties due to caregiving. They suggest that such heightened strain results from adult-children frequently needing to balance caregiving responsibilities with their own immediate family and work demands. Such findings are so common that Horowitz (1985) cites Brody's (1981) term for such caregiving daughters as "the women in the middle," being middle-generation, middle-aged, and in the middle of competing demands on their time.

Similarly, this study found that daughter caregivers, in comparison with husband caregivers, experienced greater Anxiety/Depression Symptoms during caregiving, which may be an indirect measure of burden. Such symptoms as headaches, restlessness, sleep

disturbance, and changes in appetite and weight can often occur in individuals experiencing heightened stress. To the extent that caregivers experience greater levels of caregiving strain and burden, they may also be more likely to experience symptoms as those found in the Anxiety/Depression Symptoms factor.

Most research examining gender differences in caregiver strain focus on comparisons between husband and wife caregivers. While these comparisons are not directly relevant to this study, as wife and daughter caregivers' experiences are likely not equal, their interpretation of the husband caregiver's experience provides some insight for potential explanations of differences found between husband and daughter caregivers. Gender differences between husband and wife caregivers may be due to differences in meanings that these caregivers associate with the caregiving role (Mui, 1995). Mui suggests that husband and wife caregivers' experiences may differ qualitatively as men and women differ in how they define the context of caregiving. For example, in the face of other role losses experienced in later life, older husband caregivers may perceive caregiving as a meaningful retirement activity. Furthermore, husbands may derive positive feelings from caregiving because it requires that they are in charge of the situation, thus extending the traditional male role of authority (Mui, 1995). Thus, the caregiving role is seen as a task that provides new meaning to the husband caregiver's life, which places the husband in the familiar masculine role of authority in the relationship.

In addition to adding a sense of purpose to the caregiver's life, caregiving also places the caregiver in a role of authority over the patient. To the extent that men are more familiar with playing the authority role in the household, the additional responsibility for patient care may be less anxiety provoking for them. To the degree that husbands, in comparison to wives, are more accustomed to and more comfortable holding

a position of authority within the household, husband caregivers' may experience less distress during caregiving than wife caregivers who may be less accustomed holding an authority role in the household (Mui, 1995). This explanation may also hold true for differences between husband and daughter caregivers. For daughters, being responsible for a parent is a definite change in the established direction of authority in the parent-child relationship. Adult-daughters, who have grown up viewing their parents as authority figures, may find some difficulty with the abrupt change in family role status that occurs when they become a caregiver for a parent, in this case for their mother. These daughters are suddenly responsible for their mother's care, and often become the leader of the household, inheriting all the responsibilities that entails. For daughter caregivers, such a change in role may involve a greater need for adjustment than may be the case for husband caregivers who are more accustomed to their authority in the household. As a result, daughter caregivers would likely experience greater anxiety while adapting to this new role than would husbands who may be more accustomed to the role.

Consequently, the greater anxiety symptoms experienced during caregiving by daughters, in comparison to husbands, may be associated with the daughters' greater unfamiliarity or discomfort with taking on the authority role in the parent - adult-child relationship, which is assumed during caregiving. To the extent that daughters experienced difficulty and stress in this role, symptoms such as headaches, restlessness, sleep disturbance, and changes in appetite and weight are to be expected. Therefore, for daughter caregivers, it appears that anxiety symptoms experienced during caregiving have a multidimensional foundation, likely including such factors as the burden of additional responsibilities added to their pre-existing life demands, as well as their adjustment to a change in role experience wherein they reverse the authority role with their mothers who had held that position over them throughout their lives.

Husband and Daughter Bereavement Experience

It is frequently expected that spouse caregivers would have greater difficulty adjusting to the death of the patient than adult-child caregivers, due to the difference in the type of loss experienced by the caregiver. Spousal relationships are often viewed as being more intimate and interdependent than the relationships between adult-children and their parents. Based on this assumption, the experience of loss should in turn be greater in spousal relationships. Despite differences in the level of anxiety symptoms experienced during caregiving, however, this study found that husband and daughter caregivers did not differ in their levels of grief and despair ninety days after patient death.

Other studies also have found evidence contrary to the assumption that spouses will experience greater difficulty with bereavement adjustment. In a study of caregivers for dementia patients, Aneshensel et al. (1995) found no difference in the bereavement reactions between adult-children and spouse caregivers. Aneshensel et al. provided four possible explanations for these unexpected results that are applicable to this study as well. First, adult-children who decide to take on the caregiving role may differ from those children who do not take on this responsibility. Those who take on the caregiving role may do so because they are already more deeply involved in their parents' lives than those who chose not to care for a parent. In turn, the death of the parent may impact these adult-children at a greater level than would be expected of most children because their relationship with their parent was more involved than most, and may be more similar to the level of emotional intimacy in spousal relationships. A second perspective suggests that the caregivers may not initially differ in the level of involvement in their parents' lives, but through the course of caregiving, the level of involvement increases dramatically, and in turn may bring about an emotional bond that more closely reflects

the bond in a spousal relationship. As a result, these adult-child caregivers may grieve more intensely than other adult children who had not participated in caregiving.

While these first two explanations focus on caregiving children differing from noncaregiving children, the next explanation suggests that the caregiving spouses may differ. Aneshensel et al. (1995) suggest that caregiving spouses may react less strongly to widowhood than other spouses. Throughout caregiving, spouses may already begin to experience the loss of the relationship, as they may begin the grieving process at the time that they learn their spouse is terminally ill. This process is often referred to as anticipatory grief. The sense of loss that develops over a prolonged condition such as dementia, or in the case of this study, breast cancer, may mitigate the grief that a caregiver experiences at the time of death. In addition, throughout caregiving for a terminally ill spouse, the couple has the opportunity to share their grief, as well as having the opportunity to resolve any deficiencies in the relationship (Stroebe & Stroebe, 1987).

Finally, in Aneshensel et al.'s (1995) final explanation, they question the relevance of expecting differences between spouse and adult-child caregivers. Here they suggest that the expectation of differences may be incorrectly based on the underestimate of the bond between adult-children and their parents resulting from our culture's emphasis on autonomy. The assumption that adult children are relatively uninvolved in their parents' lives and that a parent is less important than a spouse to an adult's life leads to the potential underestimation of the profound psychological bonds linking adult-children to their parents, as well as underestimation of the consequences of the parent's death to these adult children (Mullan, 1992). Aneshensel et al. suggest that the scarcity of empirical research examining adult-children's response to parent death, despite the commonality of this experience, is indicative of our culture's emphasis that adult-children are independent of their parents, and therefore should be less troubled by parental loss. However, this

may be an incorrect assumption in which adult children more strongly bond to their parents than is assumed to be the case. Clearly a need exists for more empirical research examining this relationship and the impact of parent death on adult-children. Such research could not only compare predictors of the impact of parent death, but might also compare predictive models between different groups of adult-children.

Predictors of Husband's Grief Experience and Despair

Results of this study's regression analyses indicate that for husband caregivers, caregiver age and Anxiety/Depression Symptoms during caregiving predicted Grief Experience, and Anxiety/Depression Symptoms also predicted Despair, 90 days after the patient's death. Younger husband caregiver age is predictive of greater grief. Greater anxiety symptoms during caregiving are predictive of greater grief and despair after patient death. To the extent that greater symptoms of anxiety/depression during caregiving are indicative of greater caregiver strain during this period, the finding that greater anxiety/depression symptoms during caregiving predict more difficulty with grief supports the Complicated Grief Model of bereavement. According to this model, greater strain associated with the caregiving role will lead to greater difficulty adjusting to bereavement. This pattern was supported by data from husband caregivers in this study. However, contrary to hypotheses, measures of resource loss were not predictive of grief and despair. This may be explained in terms of the caregivers' ability to cope with the loss of resources. While caregivers may all experience some degree of depleted resources, individual subjective experience of this loss may differ. Those experiencing symptoms of anxiety may be those caregivers who are experiencing greater strain or difficulty adjusting to this loss, therefore symptoms of anxiety may be a better measure of the quality of caregiver strain than the actual quantitative loss of the caregiver's resources.

Predictors of Daughters' Grief Experience and Despair

For daughters, neither Anxiety/Depression Symptoms nor Loss/Depletion of Resources predicted Grief Experience or Despair. This contradicts the prediction that daughter caregivers would experience the process of caregiving and bereavement adjustment according to the Relief Model of bereavement. According to this model, greater amounts of caregiver strain would lead to easier adjustment to bereavement, due to the relief of responsibilities, and in turn, the relief of strain, at the time of the patient's death. However, the results of regression analyses do not support either the Relief Model or the Complicated Grief Model of Bereavement for daughters. The nature of the relationship between mothers and adult daughter caregivers appears to be more ambiguous than that of the spousal relationship in terms of predicting bereavement outcome. The results of this study do not clearly point to predictors of grief or despair for these daughter caregivers.

Husband and Daughter Differences in Predicting Bereavement Adjustment

One possibility for the difference between husband and daughter caregivers' experience of strain and later grief may be due to the differences in the nature of their relationship to the patient, either husband or daughter. Spousal roles are assumed to play a more central role in people's lives than parent-adult child roles, due to the amount of time spent interacting as well as the differing levels of dependence fostered in the different relationships. Whereas daughters often live separately from their mothers and have their own immediate family for primary support, for husbands the wife is most often their primary source of support. Thus, parents are assumed to be less central to everyday life than are spouses. Accordingly, to the extent that husbands rely more upon their wives for support than daughters rely on their mothers, husbands are expected to experience a greater sense of loss with the death of their wife than daughters might

experience with the death of their mother. However, results of this study indicate that husbands and daughters did not differ in grief experience after the patient's death. Therefore, the difference in role may have more implications for a pattern of coping and bereavement adjustment for husbands versus daughters, rather than the degree of bereavement adjustment after patient's death.

Differences between husbands' and daughters' experiences of caregiver strain and later bereavement adjustment may also be an artifact of gender differences in coping. A large body of bereavement research indicates that women have better adjustment to bereavement than men. However, the focus of such research is primarily comparing widows to widowers, whereas general gender comparisons or comparisons of other female versus male caregiver groups (such as husbands and daughters) are scarce. For instance, Stroebe and Stroebe (1983) explain that this gender difference reflects differences in available social support, wherein widowers experience a decrease in alternative sources of social support with the loss of a spouse, while this pattern is not seen for widows. More researchers report widowers experiencing greater problems than widows, or no differences between gender, rather than vice versa. Stroebe and Stroebe (1983) also summarize research suggesting that men have greater vulnerability to depression following widowhood than do women. However, while several explanations for this pattern have been proposed, the literature has failed to clarify why these differences exist. To some extent, gender differences in social support may also be interpreted to exist between bereaved husband and daughter caregivers as they do between bereaved male and female spouses. Males, or husbands specifically, are more likely to depend on their spouse for emotional support and social interaction, whereas woman, or daughters specifically, are more likely to have an external source of support aside from the relationship with the patient, and are more likely to cope by searching out

such social support. To the extent that such social support facilitates the bereavement adjustment process, differences in obtaining such support will impact bereavement adjustment.

Again, the results of this study indicate that while the level of bereavement adjustment did not differ between husband and daughter caregivers, the pattern of adjustment, as it relates to caregiver strain, did differ. For husbands, greater caregiver strain predicted greater grief experience. Social support may be a mediating factor in this process. To the degree that husband caregivers had sufficient sources of social support, this may have reduced their experience of caregiver strain. As this support continued after the patient's death, it may have eased the bereavement process. On the other hand, those husbands with little or no sources of social support outside the marital relationship may have experienced greater strain with caregiving. In turn, as social support remained limited after the patient's death, bereavement adjustment may have been more difficult, as measured through greater grief experience. In contrast, daughters are likely to have had larger social networks to provide support, but consequently, these numerous social networks may also have placed greater demands on the caregiving daughter. For example, spouses and other members of the immediate family may be available for social support, but at the same time they may also be additional sources of responsibility and time demands. This is likely to be the case with other social networks as well. These greater immediate demands may have increased the daughter's experience of caregiver strain, while at the same time may have provided support throughout caregiving and later bereavement, thus easing the experience. Therefore, for daughter caregivers, the mediating effect for social support on the relationship between caregiver strain and later bereavement adjustment is more ambiguous than for husbands. Further research needs to

examine this factor directly, for its impact on both experiences for different types of caregivers.

Daughter caregivers may also fail to fit the Relief Model, or any general model of caregiving and bereavement adjustment, due to the specific nature of their mother's illness, breast cancer. Unlike other terminal diseases that have been the focus of research, for example Alzheimer's Disease or other gender-neutral terminal cancers, breast cancer may involve specific emotional significance for the daughters and not the husbands of its sufferers. Wellisch, Gritz, Schain, Wang, and Siau (1992) suggest emotional themes associated particularly with daughters of breast cancer patients that may impact the applicability of general bereavement models based on other diseases. First, these daughters experience a fear of death by breast cancer and/or identify with the mutilated body image they hold of their mother. Secondly, they may experience unresolved grief or depression regarding the loss of their mother, which may be related to insufficient time spent with the relative, particularly if the death is viewed as premature and/or preventable, for example by early detection or different treatment. Finally, Wellisch et al. suggest that these daughters may experience such anxiety regarding their own risk for breast cancer that they either avoid or are hypervigilant in effective health practices, such as observation for early detection of cancer, and this behavior subsequently contributes to lowered self-esteem. Therefore, the patient's illness is potentially another mediating factor effecting the adjustment process of caregivers, and the fact that the patients in this study were specifically victims of breast cancer may have a unique impact on their surviving daughters that reduces the applicability of any general models of bereavement adjustment.

Caregiver's Age as a Predictor of Bereavement

For husbands, old age is also a predictor of less grief, and the same trend exists for greater age to be a predictor of less grief for daughters as well. Research indicates that older individuals have better adjustment to bereavement than do younger individuals (Stroebe & Stroebe, 1987; Stroebe, Stroebe, & Hansson, 1993). It has been suggested that older individuals have greater expectations of loss and are at greater peace with the potential for death. To the extent that they have lived fulfilling lives with the deceased, they may fill more at peace with the patient's death than younger individuals that may wish to have had more time with the patient, and therefore find it more difficult to adjust to their death. Moss et al. (1993) found that younger daughters had more problems with bereavement adjustment, including greater grief, more somatic conditions, less acceptance of their mother's death, and were less comforted by memories of their mother than were older daughters. The researchers proposed that younger daughters may feel the death is unexpected or wrongfully timed, or that she was deprived of time with her mother to which she feels she was entitled. Similarly, younger spouses may also have feelings of wrongful timing and lost time with their spouse to which they too were entitled.

Stroebe and Stroebe (1993) cite several studies in which younger widowed individuals (both male and female) experience poorer adjustment than older widowed individuals. These studies indicate that initially after the death of a spouse, younger individuals experienced increased grief intensities, more severe health deterioration, and were more poorly adjusted in general than were older individuals. This study mirrors past research in that the younger husbands had more difficulty with bereavement adjustment, as indicated by greater Grief Experience. In addition, the bereavement interview was conducted at approximately 90 days after the death of the spouse, which is

within the time frame of previous research indicating that younger spouses initially experience greater difficulties with bereavement.

However, a few longitudinal studies indicate that younger bereaved spouses were better able to readjust over time, so that approximately two years after the death of a spouse, the older individuals showed exacerbated grief reactions whereas the younger individuals had significantly improved (Stroebe & Stroebe, 1987). Due to lack of additional longitudinal measures in this study, further exploration of the pattern of bereavement adjustment was not possible here. However, the nature of grief symptomatology appears to be multidimensional, and future research needs to examine how the pattern of bereavement adjustment differs between the younger and the older bereaved at different points after loss. Stroebe, Stroebe and Hansson (1993) suggest that age does not directly contribute to grief, but rather a constellation of mediating variables associated with age influence this pattern of bereavement adjustment, including initial expectation of loss, available social support, and later hope for new beginnings. However, studies directly assessing the mediating role of such proposed factors are lacking.

Limitations, Strengths and Future Directions

Several limitations to this research are associated with the use of archival data. While the data set contained a large sample of patients and caregivers who had completed numerous interviews, the original focus was targeted towards interests not addressed in this study. Therefore, the selection of interview items that addressed the issues of caregiving was limited. For example, measures of caregiver strain had to be derived from face-valid questions addressing such issues because empiracally validated measures of caregiver strain were not administered. Similarly, only a sample of the questions from the Grief Experience Inventory were originally asked, therefore the condensed measures

of grief and despair used in this study also lack empirical evidence of validity. Future research in this area would benefit from the use of validated measure of caregiver strain, providing both a general strain measure as well as specific strain factors, which would allow for the exploration of which areas of caregiver strain have a greater impact on the caregiver's wellbeing and adjustment. Also, future research examining caregivers' adjustment to bereavement would benefit from the use of validated bereavement adjustment measures, such as the complete Grief Experience Inventory.

The use of archival data limits the ability to make generalizations from research findings due to the datedness of the data. This data was collected in the early 1980s, and therefore a potential cohort effect exists to the degree that hospice care and caregiver lifestyles have changed within the past 15 years. Medical technology has advanced such that both approaches to breast cancer treatment and the actual treatment itself differs today from its early counterpart. Recent changes in healthcare management may also impact the caregiver's experience. Managed care insurance may limit the amount of professional assistance the patient receives , therefore placing more responsibility on family caregivers. Furthermore, with advances in medical technology, cancer patients are living longer, which also increases the duration of caregiving for those patients whose duration of terminal illness is lengthened as well. Thus, whereas medical technology has improved the survival rate for those afflicted with breast cancer, several recent changes in the medical field may have a negative impact on the caregiving experience, increasing the responsibilities for family caregivers.

In addition to changes within the healthcare system, societal changes have also occurred that may impact the generalizability of these results. Caregivers' lives outside of the caregiving role may also be different today than 15 years ago. For example, more women have joined the workforce, and are increasingly employed on a career track rather

than simply holding a job. In addition, due to longer life expectancies and later childbearing, an increasing number of women are being placed in a situation in which they need to provide care for both elderly parents and minor children simultaneously (Stone et al., 1987). Accordingly, these woman may experience greater role demands outside of caregiving than the daughter caregivers did 15 years ago. They may experience a greater struggle balancing loyalties to family and a career, and hence daughter caregivers today may experience greater employment strain as they engage in their caregiving role. However, all research within the field of psychosocial coping with disease and family functioning suffers from similar potential cohort effects in that referencing past research for implications on current issues is at the very foundation of research and practice in applying interventions in this area. Even so, future research would be beneficial in examining whether caregiver's role strain has increased since the time of this data collection, and what personal, societal and healthcare variables might be associated with such an increase. Research also needs to explore the impact, if any, that any changes in the level of role strain caregivers experience affected role strain's predictive value regarding bereavement adjustment. Thus, future research in this area needs to address the stability of the application of the bereavement adjustment models.

In examining the impact of role strain on bereavement adjustment for both husband and daughter caregivers, the archival data placed limitations on the ability to address confounding variables. For example, caregiver age was shown to have some predictive value regarding bereavement adjustment. Yet age is a confound with caregiver relationship, as husband caregivers are typically older that daughter caregivers. One way to address the question of the impact of age versus caregiver relationship would be to compare husband and daughter caregivers who are the same age. This study was unable to make these comparisons, however, due to the limited number of younger husbands and

older daughters. Future research may take this into account and make efforts to obtain enough members of the needed age groups of caregivers to make such comparisons. Similarly, gender is also confounded within caregiver relationship to the parent, either husband or daughter. When trying to assess the role of gender, it is possible, for example, to compare wife caregivers to terminally ill husbands, however then the stability of the disease site is lost. Disease site then becomes a confound, and research has indicated that different cancer disease sites have different implications for adjustment. In order to address all the various confounds involved in caregiver research, one would need to examine numerous studies using a meta-analysis approach. Despite potential methods for addressing various confounds related to caregiver relationship, it is important to note that the reality of the demographics is that husband caregivers tend to be older males and daughter caregivers tend to be younger females. Therefore generalities across caregiver relationships should not be made because of the unique characteristics that these two groups, husbands and daughters, bring to their caregiving situation. Thus, in terms of application of the findings, specifying unique predictors of bereavement adjustment within each group of caregivers may be more beneficial in establishing appropriate intervention processes than making comparisons between groups.

The data also included variation in whether the caregiver lived with the patient and the site of the patient's death, which future research may wish to control. Whereas all husbands lived with their wives, approximately two-thirds of the daughters lived with their mothers. This provides another confound with caregiver relationship to the patient, again emphasizing the need to examine the caregiving factors related to bereavement adjustment separately for each caregiving group, in this case husbands and daughters, because of the unique experiences group membership may entail. Daughters living with their mothers did not differ from those not living with their mothers on caregiving factors

of Anxiety/Depression Symptoms and Loss/Depletion of Resources, nor did they differ in their experience of role strain in any of the strain categories. However, those living with their mothers experienced greater despair after their mother's death than those not living with their mothers, whereas these two groups of caregiving daughters did not differ in their experience of grief.

The site of the patient's death varied similarly for those with husband and daughter caregivers across inpatient hospice, acute hospital, and other inpatient unit settings. Whereas overall caregivers experienced greater grief if the patient had died in an acute hospital than if she had died at home, when examining the individual caregiver groups, husbands and daughters, this difference in grief experience did not remain significant. The setting of patient death appears to have some impact on later grief experience, although that is beyond the scope of this study. This data set contained limited information regarding the characteristics of such settings and circumstances requiring choice of setting, which should be included in future examinations of setting impact. The focus of this research the individual group models of caregiver strain and bereavement adjustment, and in light of the lack of differences in grief and despair found when examining husbands and daughters individually, the impact of the site of death for these models of bereavement adjustment appears to be limited.

The benefit of this archival data set was its breadth in collecting data from numerous participants across a significant period of time. Data was collected from patients and caregivers across 40 hospice sites throughout the United States. Although no comparisons were made between site locations, the results appear to be statistically strong enough to likely overcome any regional differences. The large number of participants allows for fairly safe generalizations to be made regarding the caregiver experience across hospice settings within the United States. Therefore, this study has provided a picture

into the American caregiving experience for husband and daughter caregivers of terminally ill breast cancer patients. Generalizations beyond that, however, are cautioned, as site of cancer, relationship to patient, and confounding characteristics of the caregiver (age, gender) are unique to this situation and may have important implications for the relationship between caregiver role strain and bereavement adjustment.

However, the specificity in the application of these findings to caregiver populations also serves a practical benefit. Resources available to caregiving families, such as support groups, psychotherapy, and care assistance, as well as the funding for such resources, are limited. Therefore a need exists for allocating those limited resources to those who are in greatest need and have the greatest potential to benefit from specific resource utilization. Furthermore, caregivers experiencing role strain due to heightened demands of caregiving have limited personal resources such as time and energy to engage in supportive activities, and may even perceive such activities as an additional burden. Therefore, a need also exists to provide caregivers with only those resource referrals that will be the most beneficial based on the specific needs of the individual and make the best use of the caregivers limited time and energy. By specifying the unique predictors of bereavement adjustment within specific groups of caregivers, more appropriate interventions may be developed, and such interventions can be targeted more appropriately. For example, this study suggests that husband caregivers of terminally ill breast cancer patients with greater psychological and social strain during caregiving are at greater risk for bereavement difficulty. Accordingly, husband caregivers may benefit most from psychological and social interventions that provide support that may be lacking for these caregivers, as opposed to alternative sources of support that may prove less beneficial for these caregivers. Therefore, by deciphering who might be at increased risk for specific types of caregiving strain and adjustment difficulty, limited support

resources may be allocated more appropriately to provide the greatest benefit to those in the greatest need for specific types of support.

TABLES

Table 1

Comparison of Husband and Daughter Primary Care Providers on Demographics and Psychosocial Variables

	All Participants (N = 213)		Husbands (n = 126)		Daughters (n = 87)		Group Difference
	M	SD	M	SD	M	SD	t [a]
Age (range 17 to 84 years)	54.04	15.92	63.91	10.84	41.36	11.92	8.20**
Yearly Income (range 0 to 6)[b]	2.43	1.73	2.63	1.67	2.18	1.77	1.59
Education (range 1 to 20 years)	12.71	3.15	12.54	3.70	12.91	2.26	.57
Grief Experience Index[c]	0.32	0.21	0.32	0.20	0.32	0.22	.08
Despair Index[d]	0.29	0.27	0.30	0.27	0.28	0.26	.54
Anxiety/Depression Symptoms[e]	0.40	0.25	0.33	0.21	0.46	0.27	-2.92**
Loss/Depletion of Resources[e] 0.17	0.22		0.18	0.22	0.16	0.22	.71
Employment Strain	0.20	0.26	0.21	0.28	0.18	0.24	.78
Family Strain	0.14	0.17	0.01	0.16	0.20	0.17	-3.30**
Social Strain	0.15	0.29	0.15	0.23	0.14	0.23	.35
Caregiving Strain	0.24	0.14	0.21	0.14	0.26	0.14	-1.64
Psychological/Emotional Strain	0.22	0.15	0.21	0.15	0.22	0.16	-0.33
Health Strain	0.14	0.20	0.11	0.19	0.17	0.20	-1.70

[a] Ns vary between 59 and 120 for husbands and between 40 and 69 for daughters due to different numbers of missing values for individual variables.

[b] 0 = $0, 1 = Less than $5000, 2 = $5000 to $10,000, 3 = $10,000 to $20,000, 4 = $20,000 to $30.000, 5 = $30,000 to $50,000, 6 = more than $50,000.

[c] This is the full-scale measure of the Grief Experience Inventory (GEI).

[d] This is a subscale of the GEI.

[e] These factors were generated from items included in the three-week follow-up interview.

** $p < .01$.

Table 2

Items and Their Factor Loadings for Two-Factor Solution

Item #	Item Description	Factor 1[a,b] Loadings	Factor 2[a,c] Loadings
1.	Change in Appetite	.629*	
2.	Headaches	.555*	
3.	Restlessness	.534*	
4.	Family Tension	.533*	
5.	Difficulty Sleeping	.521*	
6.	Change in Weight	.476*	-.247
7.	Under Considerable Pressure	.434*	
8.	Cold Sweats	.382*	
9.	Income Loss		.683*
10.	Job Change or Job Loss	.243	.611*
11.	Change in Health		.596*
12.	Increased Need to Meet Other's Needs		.585*
13.	Loss of Significant Other		.489*
14.	Strapped Financial Resources	.301	.470*

[a] Factor loadings lower than .20 were supressed.

[b] Anxiety/Depression Symptoms

[c] Loss/Depletion of Resources

* Indicates factor assignment

Table 3

Correlations of Types of Strain Categories and Their Individual Items with Grief Experience and Despair for Husband Caregivers

Strain Category / Item	r Grief Experience	r Despair
Employment Strain	.15	.10
Strapped financial resources	.17	.13
Income change	.03	.00
Stop/reduce work	.14	.09
Family Strain	.15	.04
Increased family intimacy	--[a]	--
Family tension	.07	-.02
Family/Friends helpful	-.37*	-.28
Social/Leisure Strain	-.17	-.22
Reduced Social/Leisure Activities	-.17	-.22
Caregiving Strain	.23	.17
Hindered ability to respond to other needs	-.16	-.24
Under considerable pressure	.31*	.28
Satisfied with extent allowed to care for patient	-.10	-.09
Satisfied with ability meet patient's needs	--	--
Psychological/Emotional Strain	.50**	.52**
Seldom feel depressed	--	--
Feel fearful	.07	.04
Unusually happy	--	--

Medicating to control nerves/depression	.35*	.41**
Increased alcohol use	.35*	.35*
Suicidal thoughts	.28	.25
Feel restless	.25	.27
Difficulty sleeping	.41**	.38*
Health Strain	.17	.17
Headaches	.35*	.31*
Felt well all/most of time	--	--
Change in appetite	.10	.06
Change in weight	-.03	-.04
Cold sweats	.30*	.34*
Had plenty of energy	--	--
Health condition limits care provided	--	--

[a] Items without correlation values could not be computed due the lack of variance within the item responses.

*$\underline{p} < .05$.

** $\underline{p} < .01$.

Table 4

Correlations of Types of Strain Categories and Their Individual Items with Grief and Despair for Daughter Caregivers

Strain Category / Item	r Grief Experience	r Despair
Employment Strain	.05	.01
Strapped financial resources	.02	-.07
Income change	.14	.11
Stop/reduce work	-.03	-.05
Family Strain	.02	-.08
Increased family intimacy	--[a]	--
Family tension	.05	-.04
Family/Friends helpful	.17	.20
Social/Leisure Strain	.03	.05
Reduced Social/Leisure Activities	.03	.05
Caregiving Strain	.02	-.03
Hindered ability to respond to other needs	.06	.04
Under considerable pressure	-.01	-.06
Satisfied with extent allowed to care for patient	--	--
Satisfied with ability meet patient's needs	--	--
Psychological/Emotional Strain	.17	.11
Seldom feel depressed	--	--
Feel fearful	.09	.05
Unusually		

happy	--	--	Medicating to control
nerves/depression	.08	.10	
Increased alcohol use		-.08	-.04
Suicidal thoughts		.15	.06
Feel restless		.08	.06
Difficulty sleeping		.09	.06
Health Strain		.11	.03
Headaches		-.01	-.01
Felt well all/most of time		--	--
Change in appetite		.19	.11
Change in weight		.30*	.21
Cold sweats		.13	.06
Had plenty of energy		--	--
Health condition limits care provided		--	--

[a] Items without correlation values could not be computed due the lack of variance within the item responses.

*$p < .05$.

Table 5

Forced Entry Regression Prediction of Grief Experience Index for Husbands

Variables Entered	t	Sig t	Beta
Caregiver Age	-2.126	.040	-.296
Anxiety Symptoms	2.166	.036	.321
Loss/Depletion of Resources	.859	.395	.125

Table 6

Forced Entry Regression Prediction of Despair Index for Husbands

Variables Entered	t	Sig t	Beta
Caregiver Age	-1.166	.250	-.171
Anxiety Symptoms	2.035	.048	.319
Loss/Depletion of Resources	.665	.510	.102

Table 7

Forced Entry Regression Prediction of Grief Experience Index for Daughters

Variables Entered	t	Sig t	Beta
Caregiver Age	-1.904	.064	-.282
Anxiety Symptoms	1.379	.175	.210
Loss/Depletion of Resources	-.749	.458	-.114

Table 8

Forced Entry Regression Prediction of Despair for Daughters

Variables Entered	t	Sig t	Beta
Caregiver Age	-1.793	.081	-.267
Anxiety Symptoms	.816	.419	.125
Loss/Depletion of Resources	-1.303	.200	-.199

Table 9

Stepwise Regression Using Caregiver Strain Categories to Predict Grief Experience Index for Husbands

Variables Entered	t	Sig t	Beta
Psychological/Emotional Strain	3.499	.026	.579
Health Strain	2.309	.026	.413

Table 10

Stepwise Regression Using Caregiver Strain Categories to Predict Despair Index for Husbands

Variables Entered	t	Sig t	Beta
Psychological/Emotional Strain	3.585	.001	.796
Health Strain	2.104	.042	.505

Table 11

Comparison of Anxiety/Depression Symptoms Items Across the Three-Week Follow-up Interview and the Bereavement Interview for Husband Caregivers

	3-week Follow-up		Bereavement		Item Difference
Items	M	SD	M	SD	t[a]
Change In Appetite	.25	.44	.25	.44	.00
Headaches	.16	.37	.09	.29	1.00
Restless	.58	.50	.47	.50	1.15
Family Tension	.25	.44	.20	.41	.57
Difficulty Sleeping	.51	.51	.49	.51	.24
Change In Weight	.33	.48	.38	.49	-.42
Under Considerable Pressure	.71	.46	.27	.45	4.52*
Cold Sweats	.04	.21	.13	.34	-1.67

[a] Ns vary between 43 and 45 due to missing values.

* $p < .01$.

Table 12

Comparison of Anxiety/Depression Symptoms Items Across the Three-Week Follow-up Interview and the Bereavement Interview for Daughter Caregivers

	3-week Follow-up		Bereavement		Item Difference
Items	M	SD	M	SD	t[a]
Change In Appetite	.39	.49	.34	.48	.53
Headaches	.37	.49	.16	.37	2.46*
Restless	.65	.48	.51	.51	1.43
Family Tension	.50	.51	.30	.46	2.29*
Difficulty Sleeping	.58	.50	.60	.49	-.24
Change In Weight	.40	.49	.49	.51	-.89
Under Considerable Pressure	.77	.42	.36	.49	4.65**
Cold Sweats	.07	.26	.09	.29	-.57

[a] Ns vary between 43 and 44 due to missing values.

* $p < .05$.

** $p < .01$.

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